

VOLUME 2

REPORT NO. 11

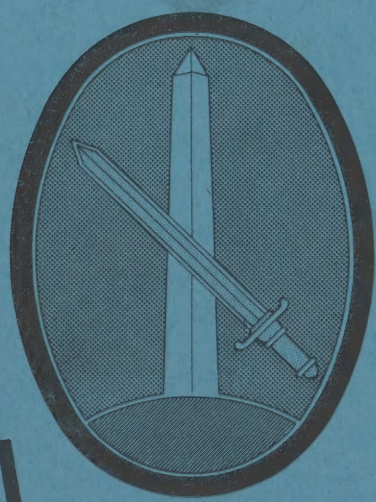
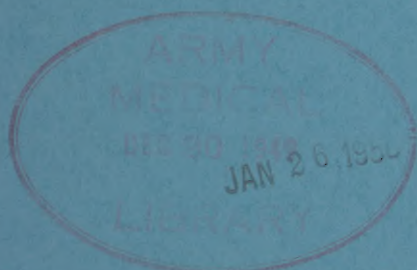
(DOCUMENT SECTION)

RESTRICTED

INDEXED

MONTHLY HEALTH REPORT

Military District of Washington



RESTRICTED

November 1949

MONTHLY REPORT

M D W

THIS DOCUMENT CONTAINS INFORMATION AFFECTING THE NATIONAL DEFENSE OF THE UNITED STATES WITHIN THE MEANING OF THE ESPIONAGE LAWS, TITLE 18, U.S.C., SECTIONS 793 AND 794. THE TRANSMISSION OR THE REVELATION OF ITS CONTENTS IN ANY MANNER TO AN UNAUTHORIZED PERSON IS PROHIBITED BY LAW.

HEALTH



HEADQUARTERS, MILITARY DISTRICT OF WASHINGTON
Room 1543, Building T-7, Gravelly Point
Washington 25, D. C.



INTRODUCTION

This publication presents periodic health data concerning personnel of the Department of the Army in the Military District of Washington. It provides factual information for measurement of increase or decrease in the frequency of disease and injury occurring at each of the posts, camps or stations shown herein.

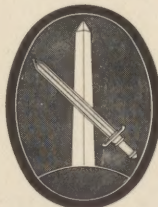
It is published monthly by the Military District of Washington for the purpose of conveying to personnel in the field current information on the health of the various military installations in this area and on matters of administrative and technical interest. Items published herein do not modify or rescind official directives, nor will they be used as the basis for requisitioning supplies or equipment.

Contributions, as well as suggested topics for discussion, are solicited from Medical Department officers in the field.

FLOYD V. KILGORE
Colonel, MC
Surgeon

CONTENTS

	PAGE
PROFESSIONAL SERVICES	
Processing of Open Ward Neuropsychiatric Patients	1
PREVENTIVE MEDICINE	
Venereal Disease	3
General Comment	11
Table - General Data	12
Table - Specified Disease Rates	12
Venereal Disease	13
Table - Venereal Disease Rates	13
Chart - Admission Rates - Common Respiratory Disease - Injuries	14
Chart - Venereal Disease Admission Rates by Month	14
Table - Consolidated Venereal Disease Statistical Report	15
Table - Venereal Disease Rates, U.S.	16
Chart - Venereal Disease Total Rates	16
Chart - Venereal Disease White Rates	17
Chart - Venereal Disease Negro Rates	17
NURSING DIVISION	
Environmental Control In Tuberculosis	5
VETERINARY SERVICE	
Rabies	8
Table - Veterinary Service	18
DENTAL SERVICE	
The Dental Survey	6
Table - Dental Service	18
ADMINISTRATIVE DIVISION	
Hospital Mess Operation - Table	10
Out-patient Service - Table	18
Personnel Notes	10
Army Medical Library Publication List	19
List of Publications	20



PROFESSIONAL SERVICES

PROCESSING OF OPEN WARD NEUROPSYCHIATRIC PATIENTS

1st Lt. James W. Keenan, MSC

Office of the Surgeon, MDW

Probably the most outstanding problem in the field of military psychiatry today is the proper handling of the open ward neuropsychiatric patients. These patients are classified usually, as the mild to moderate psychoneurotic disorders, mild somatization reactions, the pathological personality types and the immaturity reactions. Of this group, the pathological personality types and the immaturity reactions are the largest group and might be loosely defined as the military psychopathic personality. This group consists of those individuals whose personalities are so deficient, as to mark them as character or behavior disorders, or those who are so immature in their responses to military life that under the slightest stress, they display an emotionally unstable personality. These personality problems comprise 75 percent of the work of the psychiatric section and in time of war, or other emergencies, their actual number becomes astounding and they literally swamp the open wards of the NP Section, actually bogging down and clogging the normal channels of psychiatric processing and treatment, and in many cases, causing severe problems in medical evacuation plans.

If an enemy force were suddenly to attack our Armed Forces, within a few days of the opening of hostilities, our open NP wards would be overflowing. We would be putting up beds in the halls, opening new wards and hospital ward census would skyrocket. This is not mere speculation. Let's consider the record: In the spring of 1943, the general staff suddenly awoke to the fact that nearly as many men were being discharged from the service, as were entering through induction stations. Over a given period of time, more men were getting out of the Army than were being sent over to fight the Japanese. The overwhelming number of these men were being discharged with "NP" diagnosis; they were mainly diagnoses of disposition convenience, in that the hospitals were overcrowded and the units refused to accept these maladjusted individuals back in their ranks. The only other legal means of disposition was a "Disability Discharge."

The faucet of disability discharge was quickly turned off, but this did not solve the problem, rather it created a bigger one. The hospitals were directed to retain the NP patients and the patient load soared until it overflowed with a roar into large convalescent areas, that were hastily set up in Field Camps. How did the Medical Department get into this predicament? To answer this question, we have to skip back to the hectic training days of 1942 and 1943, where overnight, they were trying to turn easy, freedom-loving, peaceful, zoot-suited citizens into tough, disciplined, hardened, strictly GI, combat men.

The mass production line that turned out the finished "GI" product by the millions, also turned out rejects by the thousands. The rejects were the misfits, the maladjusted, the illiterates, the alcoholic, the criminal and the other inadequates by the scores, followed by the emotionally unstable, the anxieties and other more severe mental disorders.

The rejects slowed down the training and in many cases, disrupted it entirely. The special and general courts martials were kept busy, dealing out rough disciplinary sentences to the antisocial, the alcoholic, the deserter, but nowhere in the Courts Martial Manual did it say what to do with the emotionally unstable, the schizoid, the paranoid, the cyclothymic, the immature, the euretic, or the fellow, who kept falling out of the hike with a low back pain. What to do with these individuals.

At this point many a potential combat commander, who had a tough time table training schedule to meet, was about ready to throw in the sponge. That is, until one of his staff meekly suggested that maybe these "EM" were "psychoneurotic." The commander wasn't sure what psychoneurosis meant, but it sure sounded like a quick cure for his own nerve trouble. He called for the regimental surgeon and the conversation went something like this: "Now look, Doc! You know we got a schedule to meet, how about 'racking these 8-balls' and sending them off to the psycho ward." Doc, who had been seeing these characters on daily sick call, was only too happy to oblige. So, daily, Doc sent all the "8-balls" with the diagnosis, psychoneurosis, observation for, to the hospital.

And then one fine spring morning the Chief of Staff awoke to find half his Army going home. In summary, the situation was this: In the indiscriminate drafting of large numbers of men, there were obtained many, who were emotionally or characterially ill-equipped to maintain the high standards of physical, mental or moral endurance, necessary to the making of a soldier. These men

PROFESSIONAL SERVICES

are admittedly psychiatric problems, however, they are primarily high level personnel problems, in that their limited abilities should be utilized outside of the military service, where they would have a larger area, under less rigid pressure to make an adjustment of their deficient personalities.

However, the reality of the situation is that they are in the service and are fairly well scattered throughout all units. Because of their inadequacies they are serious problems to field units, in that they keep these units from obtaining combat readiness, or training perfection, they prevent a real "esprit de corps," for they maintain no loyalty to any person, group, or code. They increase the VD and courts martial rate. They are even more of a problem to the military service in general, because their acceptance, long training and eventual separation from the service is a costly expenditure, which may be listed as economically wasteful. They become equally serious problems to society, after their undesirable rejection by the military service.

Since the Medical Department is charged with the proper handling of those who manifest a maladjustment to military life, it may be wise to consider ways and means of efficiently, with medical assurances, of handling this problem. There are of course, certain prophylactic measures that can be utilized, such as:

- a. Stringent mental and physical requirements for enlistment.
- b. Prevention of those who have shown previous military maladjustment from re-entering the service.
- c. Psychiatric evaluation at the inducting center.

In spite of these measures there will infiltrate a large percentage of military inadequates, whose retention in the military service is undesirable, but whose separation from the service is a costly expenditure of funds and a poor example to the perseverance of the other men. The Provisions of AR 615-369 and 368 have degenerated from their primary purpose of eliminating the antisocial and the unadaptable, into an easy means of getting out of the Army. For the EM it means when he gets in trouble, he can start "bucking" for a 369 discharge. For the Company Commander, it means an easy way of eliminating some of his leadership problems.

This is only a partial method of solving the problem, for each one so discharged, five more are enlisted the same day. It is a costly merry-go-round relationship that does not allow time for the exercising of proper leadership, nor is there any psychiatric aid given to the individual. Admittedly, if any psychiatric help is to be given it must be on a fairly intensive scale, preferably outside a hospital atmosphere. I wish to emphasize "outside a hospital atmosphere."

During the latter stages of World War II most open ward NP patients were placed in convalescent areas; this was necessitated by the fact that the number of patients far exceeded the bed capacities of the hospital; unfortunately, the convalescent areas were ill equipped both personally and materially, to cope with the large number of patients that were turned over to them, practically overnight. However, the therapeutic approach, although novel, was essentially practical.

A limited modified version of the convalescent annex would not only be a practical solution to our problem, but surprisingly, therapeutically correct treatment of open ward neuropsychiatric patients. An annex consisting of a company sized area in a nearby camp would provide adequate housing. The personnel to operate this special unit would consist of an administrative officer, with some psychological training, who could double as a guidance consultant and company administrator; help in the guidance could come from the local chaplain. Except for a few permanent party non-commissioned officers the company would be operated by the patients assigned. The entrance processing and disposition of men entering this unit would be accomplished as follows:

A patient would report to the hospital on an outpatient status, where he would be interviewed by the psychiatrist, who would determine if the man's mental condition was such that he had to be admitted. If the psychiatrist decided that the man was salvageable and amenable to psychiatric treatment, and if he was to be an open ward ambulatory patient, he would assign him to the reconditioning-rehabilitation company, at the hospital annex. He would not be admitted to the hospital proper.

PROFESSIONAL SERVICES

The men in this psychiatric rehabilitation center would undergo a modified educational, physical and recreational program, designed mainly to keep them occupationally occupied during their rest and treatment. A daily program would consist of orientation, group therapy, occupational therapy, recreational activities and physical reconditioning. This schedule would be flexible, mainly designed to keep the patients employed. During the day, the men would be under daily guidance by the psychologist and weekly interviewed by the psychiatrist. It has been our experience here and generally the experience of others engaged in military psychiatry that once a psychiatric patient gets into a hospital there arises a definite mental blocking towards his ever returning to duty. And the chances of getting him back to full duty are rather meager.

It is considered that this difficulty would be largely overcome by keeping the ambulatory open ward patients out of the hospital proper. There are of course many other advantages, such as:

1. It would free the psychiatrist from carrying the responsibility for a large number of patients and thus give him more opportunity to treat closed ward and the other seriously ill mental patients, thus providing adequate professional treatment.
2. It would enable the hospital to use their bed capacities more effectively and eliminate the disciplinary problems that the behavior disorders cause in a hospital.
3. It should cut down considerably on the number of evacuations through medical channels and increase the number of salvageable men that can be returned to duty status.
4. It will give to the patient, since he is not within the protective confines of a hospital, the proper motivation for overcoming his maladjustments and most important of all, it is the correct therapeutic approach, in that it keeps the man out of the hospital and through psychotherapeutic counselling, helps him to meet his problem in a realistic manner.

In summary, we propose an integrated administrative and medical program, which would allow for proper psychiatric treatment and the development of a more effective leadership. Administratively, this could be accomplished by the proper utilization of AR 615-369 and 368, towards the rapid elimination of the inapt and the undesirable, and a more liberal usage of the bad conduct discharge towards the prevention of the asocial and antisocial personalities from infiltrating the services. Medically, we propose a psychiatric program of rehabilitation, in a convalescent area, for those who are salvageable and amenable to psychiatric treatment.

This is no cure-all plan; it has its limitations and its results are also limited, but it is a realistic approach to a serious problem, that not only affects our military establishment, but has a telling effect on our own American civilization.

PREVENTIVE MEDICINE

VENEREAL DISEASE

1. Introduction.

a. The importance of the venereal diseases as a factor in the health of the military force is well recognized by all students of medical and military science. History bears much evidence that these diseases, spreading uncontrolled, may seriously reduce military efficiency. The experience of the U. S. Army has demonstrated, however, that prevalence of these conditions may be greatly reduced if proper measures are instituted. Much has been learned from the study of the successes and failures of the first four and a half decades of this century and particularly from the experience of two World Wars and the interim period.

b. It is not generally known that as early as 1909 The Surgeon General of the U. S. Army promulgated a definite program directed toward the control of venereal disease and sponsored field

PREVENTIVE MEDICINE

trials to determine the effectiveness of various control methods then available. Every annual report of The Surgeon General of the Army since that time has contained a discussion of the problem and an outline of the principal preventive measures in force. Thus it can be seen that the control of venereal disease has always been a serious problem and one that has been given exhaustive study in the Army.

c. Statistics available in the Office of The Surgeon General of the Army permit the computation of venereal disease rates beginning in 1819, the year the Medical Department of the Army was established as a Bureau of the War Department, and extending to the present time except for the years 1832 to 1837, inclusive, and the years 1847 and 1848. Considering this statistical evidence concerning the prevalence of venereal diseases in military personnel during the period reviewed (126 years) and the trends of occurrence of such diseases during peace and war, the following statements can be made:

(1) The highest annual rate recorded for the period was that for 1867 (215 per 1,000 strength per year) and the lowest occurred in 1943 (28 per 1,000 strength per year).

(2) With the exception of World War II, rates have increased during periods of mobilization for war and during the initial stages of war.

(3) During war periods the prevalence of these diseases undoubtedly has been influenced by the extent to which troops were engaged in vigorous training programs or active combat. During World Wars I and II the rates declined and were quite low in France and Germany where the troops were engaged in active campaigns in the field.

(4) During demobilization periods following the conclusions of wars there has always been an increase in rates and relatively higher rates have persisted for fairly long periods of time.

(5) Annual venereal disease incidence rates within the Army following the cessation of hostilities of World War II were higher than at any time within the past thirty years. This needs a little explanation. There were much higher rates in World War I but that was a short war, and the rates remained high for a very short time. This rate is expressed as an annual rate; that is, for a one year period. Following are some of the reasons for this increased rate:

(a) Presence of large numbers of men in the Army who had but one thought, to get out, and among whom military discipline and morale were at a low ebb.

(b) Decrease in effectiveness of the venereal disease control program as key personnel, officers and enlisted, were separated from the service.

(c) The cumulative effect of the widespread publicity given to the "miraculous" effects of penicillin and the sulfonamides in treating venereal diseases, counteracted the Department of the Army's educational program designed to acquaint soldiers with the advantages of continence and the necessity of prophylaxis if exposed.

(d) Systematic demoralization of German and Japanese womanhood under their former governments. These women were indoctrinated in the belief that it was right and patriotic to bear illegitimate children for any soldier of the fatherland. As members of a victorious and occupying force many United States soldiers have been unable to refrain from taking advantage of the opportunities of such a situation which is further aggravated by want and hunger in the civilian.

(e) Venereal disease measures are more effective in white troops than in Negro troops. The Negro venereal disease rate is consistently ten to twelve times the white rate.

(f) The very large reservoir of infection in the civilian population. The venereal disease rate among civilians in Berlin is more than twice that for the United States Zone of Germany.

(g) The transient character of the population in occupied areas. Many displaced persons and refugees are infected, making case finding difficult.

NURSING DIVISION

ENVIRONMENTAL CONTROL IN TUBERCULOSIS

1st Lt. Marie V. Hontz, ANC
Fort Belvoir Station Hospital

In dealing with infectious Tuberculosis, one must consider compulsory isolation as a control measure.

Forcible isolation seems to be a rather a drastic measure, and the real purpose, on some occasions, is defeated. Woodward¹ cited in his article the misuse of the Juvenile Court for such purposes. If the patient is forcibly isolated, he is very likely to be resentful and uncooperative. The family may also be influenced by this action. Nothing would be gained - in fact, it may even retard recovery. If it becomes necessary to forcibly isolate a person in order to protect those around him, the Public Health Nurse may well ask herself if she has done a thoroughly satisfactory teaching job. If the patient has not understood or is mentally incapable of grasping the situation, her educational efforts have been weak and ineffective. Forcible isolation may be necessary for the protection of others, but every effort should be made to educate the infected person; in the long run it will be more lasting. Forcible isolation is temporary. It is destructive to our efforts to build up community confidence in the medical profession and in the modern sanatorium. What we should do is to analyze the patient's resistance to proper treatment. Perhaps the roots of resistance are imbedded in conditions we have overlooked; therefore, the only advantage in forcible isolation is the temporary removal of an infectious case.

Tuberculosis is an illness, and the patient needs instruction, understanding and help - not a court procedure.

Procedures which may be used to safeguard the environment of an infectious patient:

Ultra-violet radiation controls air-borne bacteria and reduces infection. Experiments have shown that adequate, properly installed ultra-violet ray will reduce the number of bacteria in the air. Microorganisms injected in droplets suspended as nuclei are destroyed by this method at a rate far greater than can be accomplished by mechanical ventilation. Dr. Lurie² pointed out that where ultra-violet ray was used in experiments on rabbits, none of the rabbits died, and that in the irradiated air, bacilli were killed. Ultra-violet rays do not penetrate deeply. He concluded that particles concerned in infections are extremely minute. If large dust particles contained the bacilli, ultra-violet rays would not be able to destroy the organisms.

In order to safeguard others, the patient must cover mouth and nose when sneezing or coughing. A good supply of paper napkins should be available in a container conveniently placed on the bedside table. This is essential to the faithful practice of this prophylactic measure. The paper napkins should be large enough to give adequate protection. The convenient location of the napkins is not enough; the patient must be taught how to use them correctly. In order to properly receive the droplets in the paper napkin, it is suggested that the hand, held cupshape, be lined with several thickness of paper. It is the nurse's duty to properly instruct the patient by actually demonstrating the procedure. She must explain the reasons for proper use of the napkin, i.e. that the tubercle bacilli will not be disseminated into the air. Unless napkins are adequately large, proper protection will not be practiced. This prophylactic measure is equally or more important in preventing the spread of tuberculosis than all other prophylactic measures combined. So that the nurse is able to instruct the patient properly, she should practice it herself. She must emphasize the use of this protective measure both when the attendant is present and when not. She must emphasize control measures where the patient is unable, or too ill, to care whether others are infected. She must instruct in and carry out a rigid contagious isolation technique. When giving bedside care, the nurse as well as the patient should wear a mask.

It is necessary to have the patient wear a mask because he may be too ill or unable to use the paper napkins while receiving bedside care. The patient may forget the procedure because of his interest in what is being done for him at the moment.

A gown should be worn by the nurse or attendant and should adequately cover the person wearing it. Proper gown technique must be carried out.

NURSING DIVISION

Disposal of sputum is important, and the attendants are thus directly exposed to the infection. Use of paper napkins which are discarded in a stout paper bag seems to be a better technique than use of the sputum cup. Paper bags can be removed and burned easily, while contents of sputum cups may be spilled on the floor or over bed-clothing. A clean napkin can be used to wipe the mouth and immediately placed in the paper bag for disposal. This method certainly would seem to be more sanitary and can safely be used in the home.

The boiling of linens, dishes, etc. and careful washing of the hands are other safeguards. Tubercle bacilli are destroyed by heat; 70% alcohol is effective after hand-washing. The following technique should be used in cleansing the hands: Thoroughly wash hands with soap under running warm water. Particular attention should be given to the fingernails and the skin between the fingers. It may seem unnecessary to stress handwashing as important, since every nurse has been taught how and why it should be done, but the writer has observed a lot of inadequate and careless hand-washing. It must be kept in mind that the patient's room is a contaminated area and must be kept isolated and clean.

The nurse must teach precautionary procedures to others in the patient's surroundings in order to safeguard them. She must practice what she teaches.

References:

1. Editorial: "Compulsory Treatment for Tuberculosis"--American Journal of Public Health, Volume 34, Number 5, May 1944.
2. Author's Lecture Notes.
3. H. W. Hetherington, M.D. and Fannie Eshleman, RN, BS: "Nursing in Prevention and Control of Tuberculosis." 1945.

DENTAL SERVICE

THE DENTAL SURVEY

A dental survey is a process whereby the dental efficiency of a group is determined. It is a group classification of all of the individual members of a command or unit which is arrived at by a rapid yet accurate oral examination of its members. Such an examination is one made of an assembled group by visual inspection usually aided by tongue depressor only though occasionally assisted by the mouth mirror and explorer examination. Such a survey is not to be confused with the "Report of Dental Survey" which is the oral examination recorded on the reverse of the Register of Dental Patients, WD AGO Form 8-116. An annual survey of a command is required by Army Regulations which specify that this survey will be made between 1 January and 30 June of each year or more often when indicated by local conditions (AR 40-510). While such a survey is required actually but once each year it will usually be found that one will be necessary at more frequent intervals. Local conditions, such as the rapid turnover in personnel and the transfer of individuals into and out of the organization will cause surveys to be necessary more often.

A dental survey should be the logical beginning to the rendition of dental service to any group of individuals. Thus, the newly assigned dental officer should first look for a dental survey which may have been made by a predecessor and which, if considerably outdated, should be discarded and a new survey made prior to initiating a program of providing dental attention to his organization. A dental survey to be of value must, of course, be accurate and, in addition, it should be performed and recorded in a uniform manner so that any dental officer other than he who made the survey, could readily analyze it and find it useful.

Individuals are classified according to findings upon survey or examination into the following classes and subclasses as listed in AR 40-510 and which are quoted on page 7.

DENTAL SERVICE

- "(1) Class I. Persons requiring immediate treatment.
- (a) Traumatic injuries.
 - (b) Acute infection (pulpitis, gingivitis, stomatitis, etc.).
 - (c) Conditions necessitating extraction.
 - (d) Insufficient teeth to masticate the army ration.
 - (e) Defects not listed above but of a nature requiring emergency treatment.
- (2) Class II. Persons requiring early treatment (favorable cases for prevention dentistry except persons in Class I) such as:
- (a) Filling operations which do not involve pulp canals.
 - (b) Replacement of defective fillings (except root canal fillings).
 - (c) Prophylactic treatment.
 - (d) Correction of defects not listed above but of a nature favoring preventive procedures, including orthodontia.
- (3) Class III. Persons requiring extended treatment (constructive dentistry except persons in Class I or Class II) such as:
- (a) Treatment of chronic infections.
 - (b) Filling operations involving root canals.
 - (c) Replacement of defective root canal fillings.
 - (d) Construction of crowns, bridges, and dentures for those not coming under (1), (d) above.
 - (e) Correction of defects not listed above but of a nature requiring extensive treatment.
- (4) Class IV. Persons not requiring dental treatment."

Dental surveys are normally conducted at some place other than in the dental clinic and it is usually expedient to arrange to conduct the dental survey at a time when the organization or a majority of its members are already assembled for some other formation. It is believed that a most suitable formation at which to conduct such a survey is on the last day of a month when the troops are assembled at the pay table; firstly, because a maximum number of individuals are usually present at such a formation and, secondly, because they are already formed in suitable order from which to conduct a survey. The commanding officer of the organization should be consulted in advance of making any survey and he will doubtless approve the proposal to make a dental survey since the health of his command is his responsibility and he is, therefore, anxious to receive assistance in carrying out that responsibility. The commanding officer will likely call in his first sergeant and instruct him to give all necessary assistance. The first sergeant should then be asked to have at least two copies of a roster of the organization prepared in advance of the time for the survey and he should be also asked to stand by at the place of the survey to assist in the identification of the men as they pass by the surveying station. The roster should be prepared in the same order as the pay roll muster which would then list the men alphabetically and by rank for then the men will appear before the dental officer after leaving the pay table in a logical order. The first sergeant will be the first man to leave the pay table and he can then stand by to readily identify each man. The dental officer and his assistant station themselves at some point beyond the pay line and each man stops to

DENTAL SERVICE

be examined by the dental officer who will call out the classification and subclassification of the individual as he then sees it. The assistant will then make suitable indication thereof after the individuals' name on the roster. It is important to classify the individuals examined by listing both a class and a subclass for each according to those shown listed in AR 40-510, for thereby a suitable and logical priority for attending to those requiring treatment is set up. A list of the absentees is made and the first Sergeant is instructed to have these men report to the dental clinic at the earliest possible date for an examination and classification.

The results of the survey should be summarized when completed and a copy of such a summary presented to the commanding officer of the organization. Such a summary need show only the total numbers of individuals in Class I, II, III, and IV within his command. In this way the commanding officer is informed as to the present dental health of his command. The summarized classification is used to report the classification of military personnel in Section 4 of the Report of Dental Service, WD AGO Form 8-98, for the month in which the survey was completed. In subsequent months the classification figures are modified and corrected by accurately changing them as the result of treatment of patients, by dropping those transferred out of the organization, and by adding the classification of newly joined personnel.

The roster is used by the dental service then in systematically calling in those individuals found to be in need of treatment. Patients should be called in for treatment according to those having the greatest need for dental attention. This priority was previously set up at the time of the dental survey by placing all individuals in appropriate classes and subclasses, those found to be in Class I (a) being called in first, and so on until all those in need of treatment have been attended.

VETERINARY SERVICE

RABIES

Very recently several cases of rabies in dogs have been reported and diagnosed in areas surrounding the District of Columbia. A number of small children have been exposed to these infected animals. These youngsfolks have received the Pasteur treatment. The areas involved are now requiring all dogs to receive protective inoculations and have invoked a strict quarantine confining all dogs for a period of ninety days. Violations of these restrictions carry a relatively heavy fine. The Armed Forces within this area (Military District of Washington) are cooperating with all control measures and are working very closely with the local public health officials on this problem.

Rabies cannot be cured but can be prevented. The reported incidence of this disease has increased in various parts of the United States during the past ten years. Each year over 30,000 persons take the long and painful series of inoculations because of exposure to either rabid or suspected rabid animals. The annual loss of livestock in the U. S. due to rabies is over 10,000 animals. The yearly cost of human inoculations, together with the losses of livestock are estimated to total over five million dollars.

Several countries of the world, including England and Australia, have controlled and eradicated rabies. There are areas in the United States that have controlled this disease, using the approved and available methods.

An effective rabies control program should include the following measures:

1. Education of the population to desire the eradication of the disease.
2. Annual immunization and licensing of resident dogs and cats.
3. Removal of all stray dogs and cats in the community.

VETERINARY SERVICE

4. Strict general quarantine measures over a sufficiently wide area during an outbreak. (County is best size.)
5. The proper disposition of suspected and rabid animals and confirmation of the diagnosis by laboratory methods.
6. Dogs known to have been exposed to rabies should be destroyed or kept confined for a period of not less than six months.
7. Reduction of wild animal reservoirs.

The best known of Pasteur's many accomplishments was the development of the anti-rabic vaccine treatment. It was Pasteur who found that the virus present within the spinal cords of rabbits, having succumbed to a fixed rabies virus, could be gradually reduced in virulence by drying the cords over sodium hydroxide. Improvements in this technique have been made since Pasteur's original work was accomplished. Rabies vaccine now produced is uniform in potency, being tested by means of the Habel Mouse-test under the supervision of the United States Bureau of Animal Industry.

An important part, of any rabies control program includes the inoculation, is not a substitute for the measures listed above but should be supplemented with the other steps.

The rabies control program maintained by the Armed Forces is carried out under the supervision of the veterinary officers of the Army and Air Force. It has for its purpose the prevention of this scourge among troops and animals, including pets of members of military establishments. In areas, near or surrounding military installations, where rabies appears within the civilian population, the Army veterinarian works voluntarily with the local Public Health authorities. This co-operative type of program is an aid to the civil authorities in their efforts towards rabies control.

About ninety percent of rabies cases occur in dogs. Stray and ownerless dogs aid in the spread of this disease. In some areas, wild animals help to perpetuate rabies and transmit it to domestic animals in disease free areas. The fox, skunk and squirrel are the most common wild animals involved in the United States. In some South and Central American countries, vampire bats transmit rabies for long periods without themselves showing symptoms. Animals suspected of being rabid should not be killed but should be captured, isolated and held for observation for a period of at least 15 days or until definite symptoms of rabies appear. If the animal is to be killed the brain must not be damaged, (such as shooting through the head), because diagnostic examinations and tests require tissues from this organ.

Heads of animals who are suspected of rabies should be forwarded to the nearest diagnostic laboratory in a water tight metal container insulated and refrigerated with sawdust and ice. When more than 24 hours are required for transit, only the preserved brain should be sent; one half in neutral glycerine and one half in 10% formalin.

Fifteen percent of the total heads received by the laboratory are negative to direct microscopic examinations but are positive when animal inoculations are utilized. In many laboratories a 10% suspension of brain tissue is routinely injected intracerebrally into at least five mice. Rabies virus will usually produce typical symptoms and cause death within nine to fourteen days, and their brain tissue will show Negri bodies upon microscopic examination.

Rabies can be controlled and eradicated. The intelligent cooperation of Public Health officials, physicians, veterinarians and the general public is vital for effective results. No country need tolerate rabies.

ADMINISTRATIVE DIVISION

PERSONNEL NOTES

During the month of October 1949, the following personnel joined the Military District of Washington units indicated:

NAME	RANK	BRANCH	ORGANIZATION
Levine, Leon	Captain	MC	7071 ASU Ft. Belvoir
Bres, Edward	Captain	MC	7071 ASU Ft. Belvoir
Dowless, Joseph D. Jr.	Captain	MSC	7004 ASU General Dispensary, USA
Keenan, James	1st Lieutenant	MSC	7001 ASU Headquarters, MDW
Rybolt, James	1st Lieutenant	MSC	7099 ASU Ft. Churchill
Pelet, Mariska	Captain	ANC	7071 ASU Ft. Belvoir
Hegarty, Mary	1st Lieutenant	ANC	7071 ASU Ft. Belvoir
Kehoe, Lelia	Captain	ANC	7071 ASU Ft. Belvoir
Knox, Grace	1st Lieutenant	ANC	7071 ASU Ft. Belvoir
Mead, Pettrina	2nd Lieutenant	ANC	7071 ASU Ft. Belvoir
Mullins, Evelyn	2nd Lieutenant	ANC	7071 ASU Ft. Belvoir
Rousseau, Celeste	1st Lieutenant	ANC	7071 ASU Ft. Belvoir
Vandenberg, Rika	1st Lieutenant	ANC	7071 ASU Ft. Belvoir
Biss, Elizabeth	1st Lieutenant	ANC	7071 ASU Ft. Belvoir
Miller, Gladys	1st Lieutenant	ANC	7071 ASU Ft. Belvoir

The following personnel departed from the Military District of Washington organizations indicated during the month of October 1949.

NAME	RANK	BRANCH	ORGANIZATION
Power, Lawrence	Captain	MSC	7001 ASU HQ, MDW - Transferred to Beaumont GH, Texas
Dunsmore, Elizabeth	Captain	ANC	7071 ASU, Ft. Belvoir - Transferred to Lackland AFB, Texas
Mareinkoski, Helen	Captain	ANC	7071 ASU, Ft. Belvoir - Transferred to Eglin AFB, Florida
Pollard, Bertha	Captain	ANC	7071 ASU, Ft. Belvoir - Transferred to 2201st Hosp Sq., Washington, DC
Williams, Mae	Captain	ANC	7071 ASU, Ft. Belvoir - Transferred to Robins AFB, Macon, Georgia
Barrett, Margaret	1st Lieutenant	ANC	7071 ASU, Ft. Belvoir - Transferred to 2200th Hosp Sq., Waltham, Mass.
Casey, Corrine	1st Lieutenant	ANC	7071 ASU, Ft. Belvoir - Transferred to Lackland AFB, Texas
Goeller, Dorothy	1st Lieutenant	ANC	7071 ASU, Ft. Belvoir - Transferred to Lackland AFB, Texas
Miller, Marion	1st Lieutenant	ANC	7071 ASU, Ft. Belvoir - Transferred to Bolling AFB, Washington, DC
Baker, Margaret	1st Lieutenant	ANC	7071 ASU, Ft. Belvoir - Transferred to 3440th ASU, Ft. Benning, Georgia
Yetter, Orville	Major	MC	7071 ASU, Ft. Belvoir - Transferred to Great Falls AFB, Great Falls, Montana
Hayworth, Helen	1st Lieutenant	ANC	7071 ASU, Ft. Belvoir - Transferred to Beaumont GH, Texas
Van Horn, Mary	1st Lieutenant	ANC	7071 ASU, Ft. Belvoir - Transferred to Bolling AFB, Washington, DC

HOSPITAL MESS ADMINISTRATION (Data from WD AGO Form 8-210)

STATION	July 49	August 49	September 49	October 49
FORT BELVOIR				
Income per Ration	\$ 1.090	\$ 1.088	\$ 1.192	\$ 1.062
Expense per Ration	1.029	1.047	1.104	1.047
Gain or Loss	+0.061	+0.041	+0.088	+0.014

PREVENTIVE MEDICINE

RESTRICTED

GENERAL COMMENT

The health of the command continued to be satisfactory.

Unless otherwise indicated, reference to disease and injuries in this publication applies to all Class I and II installations exclusive of Army Medical Center, Walter Reed General Hospital. Rates are calculated on the basis of a thousand mean strength per year. Statistics presently reported by Army medical installations do include those Air Force personnel who are treated or hospitalized at the reporting unit on a casual basis, since reciprocal use of either service's medical installations is made. Air Force statistics are tabulated separately for units having Air Force personnel assigned.

The non-effective rate decreased over the September rate of 8.49 to 7.43 for the month of October. Days lost as a result of disease and injury totaled 3847 during October. A total of 5429 days lost was reported for the five week period ending 30 September 1949.

The total admissions for disease and injury in October were 452; of this number 384 admissions were for disease and 68 admissions for injuries. The admission rate for October for all causes was 317.1, which may be compared to the September rate of 338.6. The General Dispensary, USA, The Pentagon, continued to report the lowest rate for all causes with 199.9 and Fort Lesley J. McNair the highest with 596.6.

The incidence of injuries decreased from 80 cases in September to 68 cases throughout October. However, the rate for October was 47.8 as compared to 45.5 for September; this difference may be reconciled by reason of September being a 5 week report period and October a 4 week report period. The General Dispensary, USA, The Pentagon reported the lowest rate of 11.3 and Fort McNair reported the highest rate of 124.9.

The incidence of disease decreased from 515 cases in September with a rate of 293.1 to 384 cases and a rate of 269.9 in October. Units listed as "All Others" reported the lowest rate of 155.8 and Fort Myer (South Post) reported the highest with a rate of 509.4.

No Certificates of Discharge for Disability were processed during the month of October pending revision of regulations.

No deaths were reported by installations throughout the four week period ending 28 October 1949.

COMMUNICABLE DISEASE

Common respiratory diseases decreased in incidence during the month of October with 80 Cases reported, as compared to 85 during the previous report period. The rate for October increased over rate for September. The rates were 56.2 and 48.4 respectively.

Admission rates for pneumonia all types increased during the month of October to 6.3 as compared with a rate of 5.1 in September.

No cases of measles, mumps, scarlet fever or malaria were reported throughout October 1949.

Diarrhea, influenza, tuberculosis and other communicable diseases reflected no appreciable change during the month.

Pertinent statistical tables may be found on pages 12 and 14..

RESTRICTED

PREVENTIVE MEDICINE

RESTRICTED

GENERAL DATA
4 Week period Ending 28 October 1949
(Data from WD AGO Form 8-122)

STATION	MEAN STRENGTH			DIRECT ADMISSIONS						Non-Effective Rate	Number of CDD's	Number of Deaths
	Total	White	Negro	All Causes		Disease		Injuries				
				Cases	Rates	Cases	Rates	Cases	Rates			
Fort Belvoir (A)	9,091	7,516	1,575	185	264.5	159	227.3	26	37.2	12.50	0	0
(AF)	192	192	0	7	473.9	6	406.2	1	67.7	21.76	0	0
Fort McNair (A)	937	854	83	43	596.6	34	471.7	9	124.9	3.05	0	0
(AF)	94	94	0	0	-	0	-	0	-	-	0	0
Fort Myer (North Post) (A)	1,542	1,326	216	59	497.4	50	421.5	9	75.9	4.17	0	0
(AF)	0	0	0	2	-	2	-	0	-	-	0	0
Fort Myer (South Post) (A)	1,812	1,812	0	80	574.0	71	509.4	9	64.6	3.06	0	0
(AF)	0	0	0	0	-	0	-	0	-	-	0	0
General Dispensary, USA (A)	3,447	3,418	29	53	199.9	50	188.6	3	11.3	1.92	0	0
(AF)	3,294	3,283	11	78	307.8	69	272.3	9	35.5	2.43	0	0
All Other (A)	1,669	1,669	0	32	249.3	20	155.8	12	93.5	1.41	0	0
(AF)	22	22	0	1	590.9	1	590.9	0	-	4.87	0	0
Total Mil Dist of Wash (A)	18,498	16,595	1,903	452	317.7	384	269.9	68	47.8	7.43	0	0
(AF)	3,602	3,591	11	88	317.6	78	281.5	10	36.1	3.47	0	0
AMC - Med. Det (Duty Pers)*	1,565	1,400	165	42	348.9	41	340.6	1	8.3	2.33	0	0
AMC - Det. of Patients*	1,054	955	99	130	1,603.4	110	1,356.7	20	246.7	996.37	0	5
AMC - Total (Army)	2,225	1,985	240	134	782.9	119	695.3	15	87.6	364.49	0	2
AMC - Total (Air Force)	395	370	25	38	1,250.6	32	1,053.1	6	197.5	614.74	0	3
AMC - Total (A & AF)	2,620	2,355	265	172	853.4	151	749.2	21	104.2	402.22	0	5
Total Dept/Army Units	20,723	18,580	2,143	586	367.6	503	315.5	83	52.1	45.77	0	2
Total Dept/Air Force Units	3,997	3,961	36	126	409.8	110	357.8	16	52.0	63.88	0	3
* Army and Air Force personnel included.												

* Army and Air Force personnel included.

ADMISSIONS, SPECIFIED DISEASES - RATE PER 1000 PER YEAR
4 Week Period Ending 28 October 1949
(Data From WD AGO Form 8-122)

STATION	Common Respiratory Diseases	Pneumonia All Types	Pneumonia Atypical	Influenza	Measles	Mumps	Scarlet Fever	Tuberculosis	Rheumatic Fever	Diarrheal Disease	Hepatitis	Malaria	Psychiatric Disease
Fort Belvoir (A)	24.3	12.9	4.3	-	-	-	-	-	1.4	-	4.3	-	4.3
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
Fort McNair (A)	41.6	-	-	-	-	-	-	-	-	-	-	-	-
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
Fort Myer (North Post) (A)	101.2	-	-	8.4	-	-	-	-	-	8.4	-	-	-
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
Fort Myer (South Post) (A)	136.3	-	-	7.2	-	-	-	-	-	-	-	-	-
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
General Dispensary, USA (A)	86.7	-	-	3.8	-	-	-	-	3.8	-	-	-	-
(AF)	153.9	3.9	3.9	11.9	-	-	-	-	-	-	-	-	-
All Others (A)	46.7	-	-	-	-	-	-	-	-	-	-	-	-
(AF)	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Mil Dist of Wash (A)	56.2	6.3	2.1	2.1	-	-	-	-	1.4	.7	2.1	-	2.1
(AF)	140.8	3.6	3.6	10.8	-	-	-	-	-	-	-	-	-
*AMC - Med. Det. (Duty Pers)	149.5	-	-	8.3	-	-	-	-	-	16.6	-	-	-
*AMC - Det. of Patients	24.7	16.0	16.0	-	-	-	-	12.3	-	-	12.3	-	86.3
AMC - Total (Army)	105.2	5.8	5.8	5.8	-	-	-	5.8	-	11.7	5.8	-	40.9
AMC - Total (Air Force)	65.8	-	-	-	-	-	-	-	-	-	-	-	-
AMC - Total (A & F)	99.2	5.0	5.0	5.0	-	-	-	5.0	0	9.9	5.0	-	34.7
Total Dept/Army Units	61.5	6.3	2.5	2.5	-	-	-	.6	1.2	1.9	2.5	-	6.3
Total Dept/Air Force Units	133.3	3.2	3.2	9.8	-	-	-	-	-	-	-	-	-

* Army and Air Force Personnel Included.

PREVENTIVE MEDICINE

RESTRICTED

VENEREAL DISEASE

Venereal disease rate among units within the Military District of Washington decreased during month of October.

The rate for October 1949 was 20.38, which may be compared to the September rate of 20.49. All units reported a lower rate during October with the exception of units listed as "All Others." For the fourth consecutive month the General Dispensary, USA, The Pentagon has reported no cases of venereal disease. Fort Myer (North Post) places second with three consecutive months with no cases of venereal disease and Fort McNair places third with two consecutive months.

A total of 29 cases were reported during the four week period ending 28 October 1949. Of this total 26 cases were reported at Fort Belvoir, 1 at Fort Myer (South Post), and 2 at units listed as "All Others."

During October, 15 cases were incurred by white personnel with a rate of 11.75 per thousand troops per annum, and 14 cases were incurred by Negro personnel, with a resulting rate of 95.64.

Of the 29 cases of venereal disease reported, 4 were diagnosed as syphilis, 22 as gonorrhea and 3 as others.

In order to enable non-professional personnel to more intelligently understand the rates of cases to personnel on duty at each designated station, we have undertaken in this issue to report the number of cases per 1000 men for this report period (October) in addition to the rate per 1000 men per annum which is not always clearly understood and is often misinterpreted.

Pertinent statistical tables and charts may be found on pages 14, 15, 16 and 17.

NEW VENEREAL DISEASE CASES - EXCL EPTS - AUGUST, SEPTEMBER, AND OCTOBER

STATION	Rate per 1000 per year	Rate per 1000 per year	Rate per 1000 per year	Cases per 1000 Troops
	AUGUST 49	SEPTEMBER 49	OCTOBER 49	OCTOBER 49
Fort Belvoir	36.97	39.91	37.18	2.859
Fort McNair	30.02	-	-	-
Fort Myer (North Post)	-	-	-	-
Fort Myer (South Post)	28.57	11.64	7.17	.551
General Dispensary, USA	-	-	-	-
All Others	-	6.40	15.58	.599
Total Mil Dist Wash Units	23.48	20.49	20.38	1.567
Army Medical Center - Total	29.43	33.15	11.69	.898
Total Dept/Army Units, Mil Dist of Washington	24.13	23.35	19.45	1.495

RESTRICTED

PREVENTIVE MEDICINE

RESTRICTED

CHART 1

ADMISSION RATES BY MONTH, ALL CAUSES, COMMON RESPIRATORY DISEASE AND INJURY
MDW RATE PER 1000 TROOPS PER YEAR

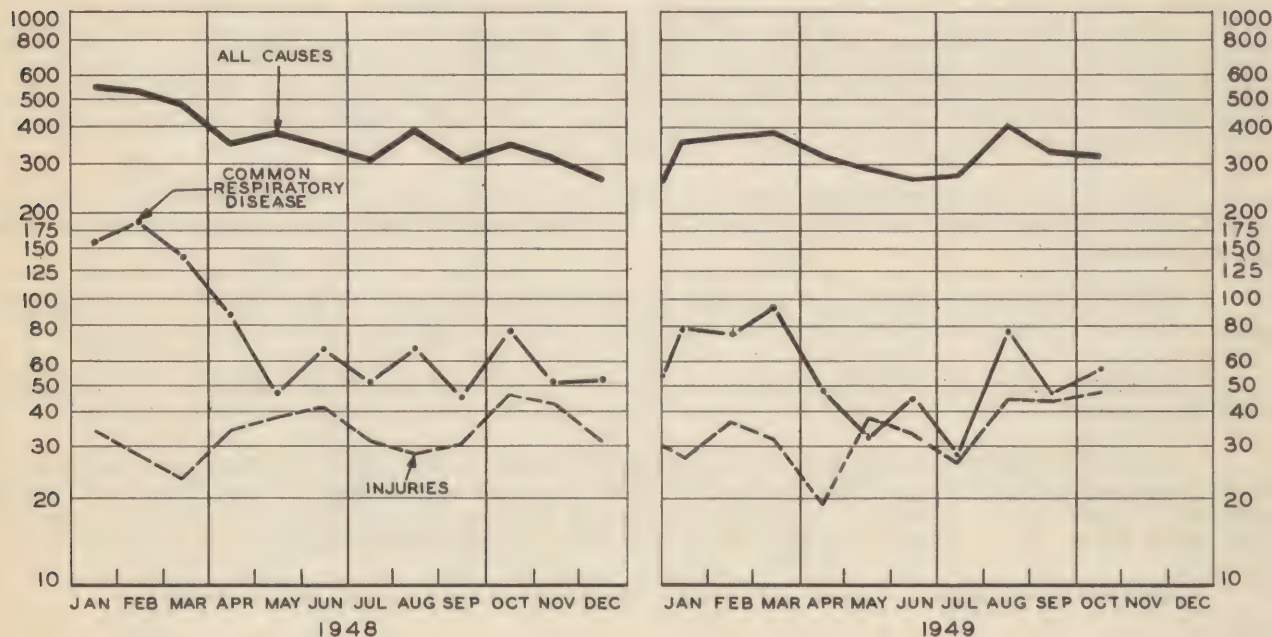
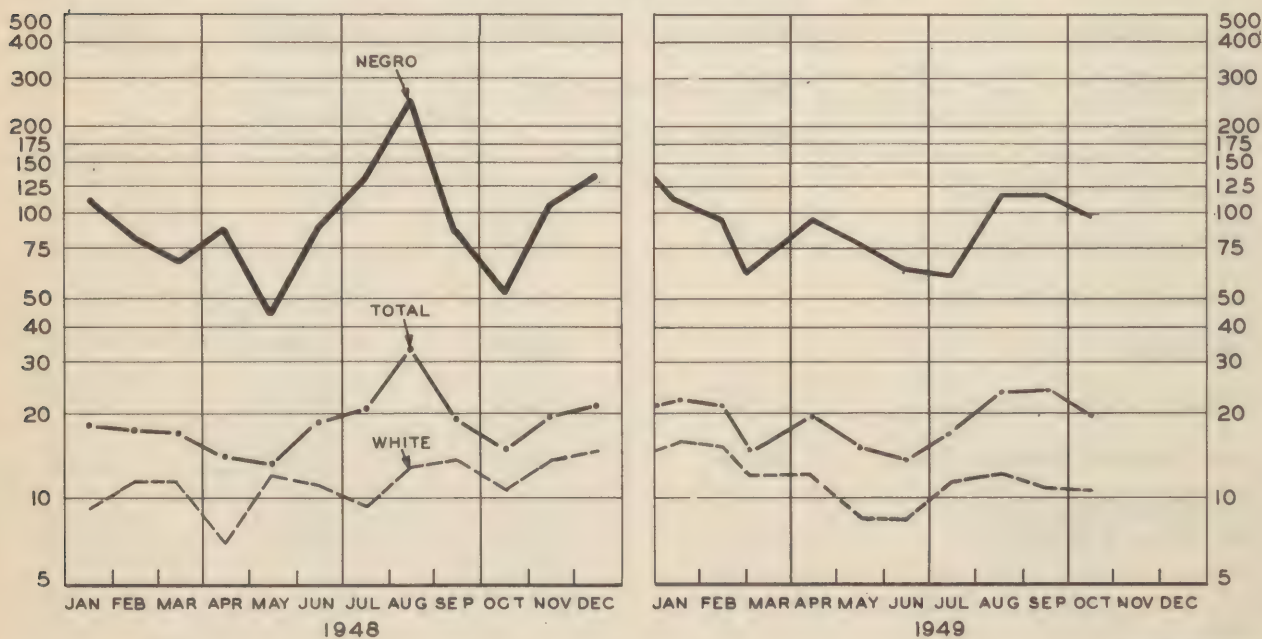


CHART 2

ADMISSION RATES BY MONTH VENEREAL DISEASES MDW INCL. ARMY MEDICAL CENTER
RATES PER 1000 TROOPS PER YEAR
INCLUDES ALL CASES REPORTED ON WD AGO 8-122 EXCEPTING THOSE EPTS



RESTRICTED

PREVENTIVE MEDICINE

RESTRICTED

CONSOLIDATED MONTHLY VENEREAL DISEASE STATISTICAL REPORT

For the Four Week Period Ending 28 October 1949

(Data from WD AGO 8-122) (Chargeable Cases)

STATION	R A C E	Mean Strength	Number of Cases-EPTS Not Included				Rate per 1000 Troops per Annum	Total Days Lost From Duty (Old & New Cases)
			Syphilis	Gonorrhea	Other	Total		
Fort Belvoir	W	7,516	1	11	0	12	20.76	6
	N	1,575	3	8	3	14	115.56	44
	T	9,091	4	19	3	26	37.18	50
Fort McNair	W	854	0	0	0	0	-	0
	N	83	0	0	0	0	-	0
	T	937	0	0	0	0	-	0
Fort Myer (North Post)	W	1,326	0	0	0	0	-	0
	N	216	0	0	0	0	-	0
	T	1,542	0	0	0	0	-	0
Fort Myer (South Post)	W	1,812	0	1	0	1	7.17	0
	N	--	0	0	0	0	-	0
	T	1,812	0	1	0	1	7.17	0
General Dispensary, USA	W	3,418	0	0	0	0	-	0
	N	30	0	0	0	0	-	0
	T	3,448	0	0	0	0	-	0
All Others	W	1,669	0	2	0	2	15.58	0
	N	--	0	0	0	0	-	0
	T	1,669	0	2	0	2	15.58	0
Total Mil Dist of Wash	W	16,595	1	14	0	15	11.75	6
	N	1,903	3	8	3	14	95.64	44
	T	18,498	4	22	3	29	20.38	50
Army Medical Center - Total	W	1,985	0	0	0	0	-	119
	N	240	0	2	0	2	108.33	195
	T	2,225	0	2	0	2	11.69	314
Total Dept/Army Units	W	18,580	1	14	0	15	10.50	125
	N	2,143	3	10	3	16	97.06	239
	T	20,723	4	24	3	31	19.45	364

RESTRICTED

PREVENTIVE MEDICINE

RESTRICTED

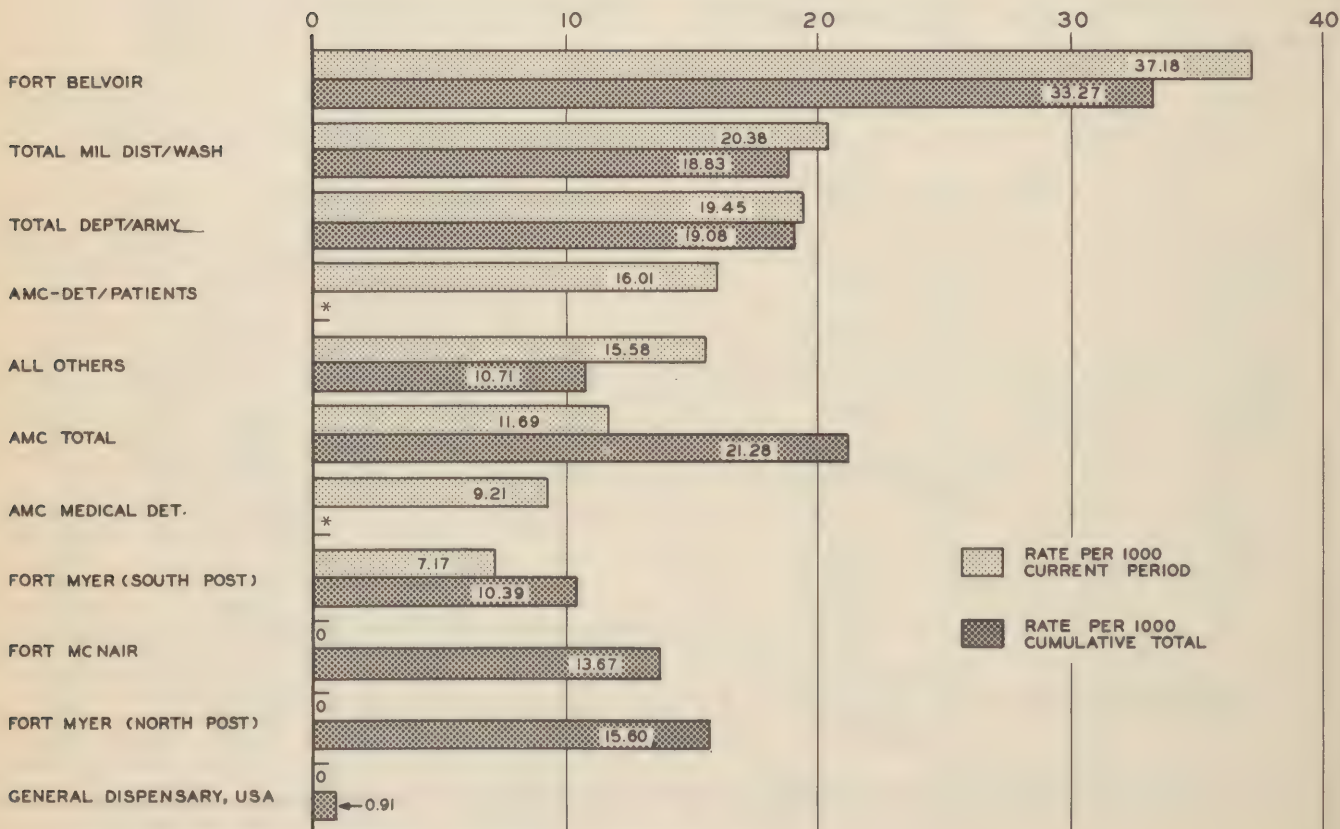
VENEREAL DISEASE RATES FOR US *

(All Army Troops)

	SEPTEMBER 1949	OCTOBER 1949
First Army Area	16	15
Second Army Area	20	21
Mil District of Washington	22	19
Third Army Area	26	25
Fourth Army Area	22	16
Fifth Army Area	19	20
Sixth Army Area	22	22
Total United States	21	20

* Compiled in the Office of the Surgeon General and includes General Hospitals.

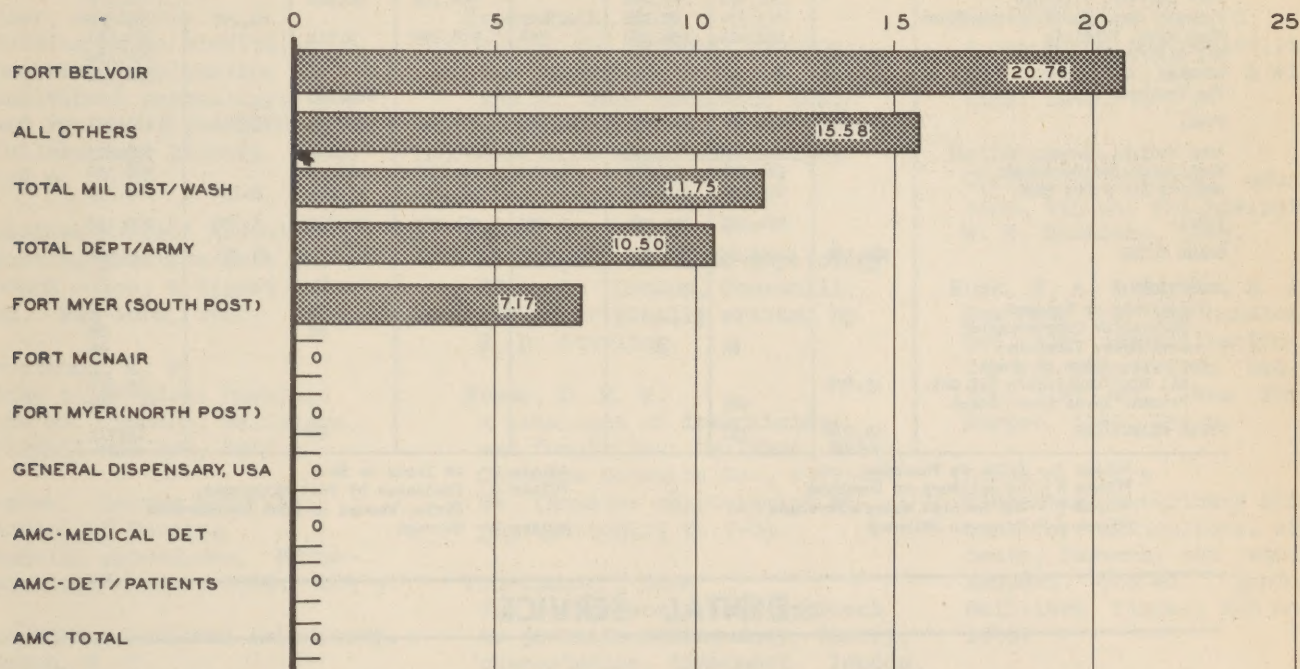
VENEREAL DISEASE RATES PER 1000 PER YEAR FOUR WEEK & CUMULATIVE TOTALS ENDING 28 OCTOBER 1949 TOTAL WHITE & NEGRO PERSONNEL (CHARGEABLE CASES)



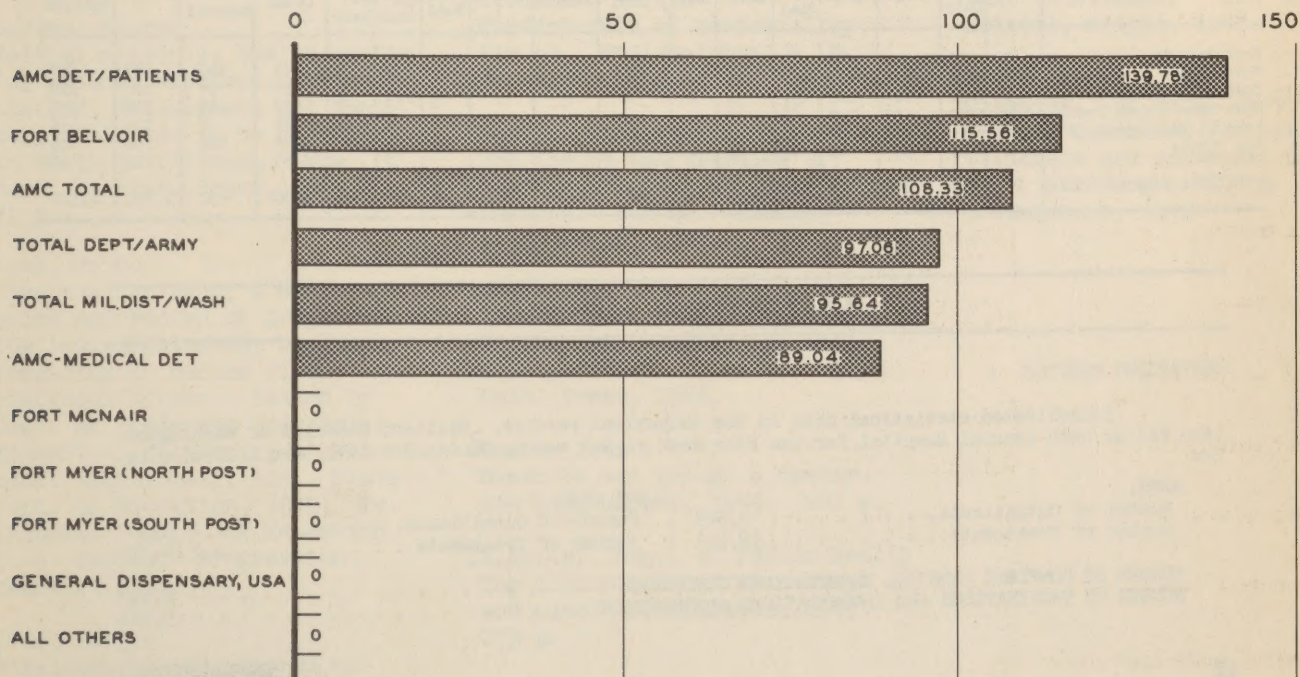
* Rate not computed due to insufficient number of reported cases.

RESTRICTED

VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR 4 WEEK PERIOD ENDING 28 OCTOBER 1949 WHITE PERSONNEL (CHARGEABLE CASES)



VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR 4 WEEK PERIOD ENDING 28 OCTOBER 1949 NEGRO PERSONNEL (CHARGEABLE CASES)



RESTRICTED**VETERINARY SERVICE**

POUNDS MEAT AND MEAT FOOD AND DAIRY PRODUCTS INSPECTED OCTOBER 1949
(Data obtained from WD AGO Form 8-134)

	CLASS * 3	CLASS * 4	CLASS * 5	CLASS * 6	CLASS * 7	CLASS * 8	CLASS * 9	TOTAL
Fort Lesley J. McNair		63,519	79,087		140,337	10,039		290,713
Fort Belvoir, Virginia		272,590	178,450		534,116	96,320		1,081,476
Potomac Yards Distribution Plant		223,534	85,795	361,802			62,093	733,224
Fort Myer, Virginia		182,010	156,269	756	378,895	9,711		727,641
Mil Dist/Washington Vet Det	224,150							224,150
US Navy	161,232							161,232
The Pentagon						267,505		
Total	385,382	739,384	499,601	362,558	1,053,348	383,575	62,093	3,485,941
Army Medical Center		201,083	75,534		276,617	6,639		559,873
Washington Quartermaster		127,174	58,917	1,530	193,330	5,379		386,330
Bolling Air Force Base		145,994	168,813		594,776	47,849	5,758	963,190
Total		474,251	303,264	1,530	1,064,723	59,867	5,758	1,909,393
GRAND TOTAL	385,382	1,213,635	802,865	364,088	2,118,071	443,442	67,851	5,395,334
REJECTIONS:								
Insanitary or Unsound								
Washington Quartermaster						88		88
Fort Myer, Virginia		64						64
Not type, class or grade								
Mil Dist/Washington Vet Det.	15,876							15,876
Potomac Yards Dist. Point		687						687
TOTAL REJECTIONS	15,876	751				88		16,715

*Class 3 - Prior to Purchase
*Class 4 - On delivery at Purchase
*Class 5 - Any Receipt except Purchase
*Class 6 - Prior to Shipment

*Class 7 - At Issue or Sale
*Class 8 - Purchases by Post Exchanges,
Clubs, Messes or Post Restaurants
*Class 9 - Storage

DENTAL SERVICE

DENTAL SERVICE--MONTH OF OCTOBER 1949

STATION	Offi- cers	Days of Duty	Sit- tings	Amal- gam	Oxy and Amal	Sili- cate	In- lays	Bridges	Bridge Repair	Crowns	Dentures			Extrac- tions	Calcu- lus Removed	X-Rays	Exami- nations
											Full	Par- tial	Re- pair				
Fort Belvoir	9	256	1,572	569	372	319	2	13	-	8	10	19	13	331	140	437	807
Fort McNair	2	62	555	539	212	87	2	-	-	1	-	11	6	56	54	126	120
Fort Myer (North Post)	2	31	887	221	37	50	-	-	1	-	2	19	6	79	19	537	276
Fort Myer (South Post)	2	59	432	298	60	58	-	-	-	-	4	8	5	36	4	110	86
General Dispensary, USA	5	144	1,953	710	143	178	5	-	3	3	7	24	16	83	208	794	729
All Others	1	25	157	42	46	32	-	-	1	-	-	3	-	53	7	10	96
Total Mil Dist of Wash	21	577	5,556	2,279	870	724	9	13	5	12	23	84	46	638	432	2,014	2,114

OUTPATIENT SERVICE**OUTPATIENT SERVICE**

Consolidated statistical data on the outpatient service, Military District of Washington, less Walter Reed General Hospital for the four week period ending 28 October 1949, are indicated below:

ARMY:

Number of Outpatients 5,504
Number of Treatments 19,314

NON ARMY:

Number of Outpatients 3,407
Number of Treatments 14,601

NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED 2,023
NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED 5,516

RESTRICTED

ADMINISTRATIVE DIVISION

Selected list of titles received by Army Medical Library, Washington 25, D. C., which were published during the last three years.

- Adler, Alexandra
Guiding human misfits; a practical application of individual psychology. (New and rev. ed.) New York, Philosophical Library, 1948. 114 p.
- American Nurses' Association
Nursing practice acts and board rules; a digest. New ed. New York, 1948. 130p.
- Armstrong, K. F.
Aids to surgical nursing. 4th ed. London, Bailliere, Tindall and Cox, 1949.
- Boston. Carney Hospital. School of Nursing.
Nursing procedures. Minneapolis, Burgess, 1949. 119 p.
- Brookhaven National Laboratory, Upton, N. Y.
Symposium on radiolodine, July 28-30, 1948, Upton, N. Y., 1948. 114 p.
- Charles, Pierre
Medical missions; the necessity for medical missions, their history, development and the many obstacles to be overcome in their fulfillment. New York, American Press, 1949. 32 p.
- Cloud, M. B.
Practical nursing; a study guide and record of progress for individual study by those preparing to become licensed practical nurses. Issued by Dept. of Trade and Industrial Education, University of Alabama. Montgomery, Ala., State Dept. of Education, 1949. 2v. (Alabama. Dept. of Education. D. O. series. Progression. chart No. 2)
- Davis, Adelle
Vitality through planned nutrition. Rev. ed. New York, Macmillan, 1949. 502 p.
- Crew, F. A. E.
Public and personal hygiene; the authorized textbook of the St. John Ambulance Association. London, St. John Ambulance Association, 1949. 128 p.
- Evans, C. A. L.
Principles of human physiology 10th ed. London, Churchill, 1949. Originally written by E. H. Starling.
- Frear, D. E. H.
A catalogue of insecticides and fungicides. Waltham, Mass., Chronica botanica Co., 1947-48. 2v. (Annales cryptogamici et phytopathologici v. 7-8).
- Friedlander, Kate
The psycho-analytical approach to juvenile delinquency; theory, case-studies, treatment. London, Routledge & Kegan Paul, 1949. 296 p.
- Frobisher, Martin
Fundamentals of bacteriology. 4th ed. Philadelphia, W. B. Saunders, 1949.
- Goodall-Copestake, B. M.
The theory and practice of massage and medical gymnastics. 7th ed. London, H. K. Lewis, 1949.
- Groves, E. W. H.
Text-book for nurses, anatomy, physiology, surgery and medicine. 7th ed. London, Oxford Univ. Press, 1948.
- Gunther John
Death be not proud; a memoir. New York, Harper, 1949. 261 p.
- Illinois. Dept. of Public Health
The Illinois hospital survey and plan. Springfield, 1947. 179 p.
- Kovacs, Richard
Radiant light and health. New York, Country Life Press, 1949. 36 p.
- Raper, K. B. & Thom, C.
A manual of the penicillia. Baltimore, William & Wilkins, 1949. 875 p.
- Rathbone, J. L.
Corrective physical education. 4th ed. Philadelphia, W. B. Saunders, 1949.
- Rusk, H. A. & Taylor, E. J.
New hope for the handicapped, the rehabilitation of the disabled from bed to job. 1st ed. New York, Harper, 1949. 231 p.
- Thompson, Henry
Elementary veterinary science for agricultural students, farmers, and stock-keepers. 6th ed. London, Bailliere, Tindall and Cox, 1949.
- Tidy, N. M.
Massage and remedial exercises in medical and surgical conditions. 8th ed. Bristol, Wright, 1949.
- Walshe, F. M. R.
Diseases of the nervous system, described for practitioners and students. 6th ed. Edinburgh, E. & S. Livingstone, 1949.

ADMINISTRATIVE DIVISION

Following is a list of publications which are of particular interest to the Medical Department:

Cir No.	DEPARTMENT OF THE ARMY CIRCULARS Subject	Date
112	Pencillin Crystalline, In Oil and Wax, 10 CC	24 Oct 49

SR No.	DEPARTMENT OF THE ARMY SPECIAL REGULATIONS Subject	Date
40-530-5	Medical Service, Hospital Patients Status and Transfer Reports From Hospitals in ZI	7 Oct 49
40-530-10	Medical Service, Hospitalization In The Army Medical Facilities In ZI of Non Military Personnel En Route To or From Overseas	17 Oct 49
600-440-1 C1	Personnel, Disposition of Psychotic	27 Oct 49

Memo No.	MILITARY DISTRICT OF WASHINGTON MEMORANDA Subject	Date
58	Hospitalization and Evacuation in the MDW	12 Oct 49
59	Medical Claims	14 Oct 49
61	Wearing of the Winter Uniform	21 Oct 49
62	Common Specialist Training in the Third Armored Division	24 Oct 49

Cir No.	MILITARY DISTRICT OF WASHINGTON CIRCULARS Subject	Date
56	Section I - Career Compensation Act Of 1949 For Warrant Officers	4 Oct 49
56	Section II - Enlisted Efficiency Reports	4 Oct 49
56	Section III - Utilization of Negro Man Power	4 Oct 49
60	Section I - Submission Of Personnel Requisitions And Reports Of Surplus Enlisted Personnel	28 Oct 49
60	Section II - Release Of Officers And Enlisted Personnel	28 Oct 49
60	Section III - Forwarding Of Service Records And Allied Papers	28 Oct 49

ANWMC File No.	PUBLICATIONS ORIGINATED IN OFFICE OF SURGEON, MDW Subject	Date
721.6	Non-Effective Rate	18 Oct 49
334	Committee On Relationship With The Armed Forces, American Association Of Health, Physical Education and Recreation	19 Oct 49

